7) Income Offsets

Income offset adjustments as defined in HIM-15, section 202.2 will continue to be made, except that income adjustments will be limited to the amount of the annual return per facility (see Table 1), plus working capital and specialty vehicle interest, in lieu of actual interest expense.

8) Limit on Cost of Capital Reimbursement

Cost of capital reimbursement effective July 1, 1989 cannot exceed the audited cost of capital and return on equity per diem payment reimbursed prior to July 1, 1989 (i.e., cost of capital and return on equity per diem payment on June 30, 1989) by more than $3.00 per patient day. The $3.00 cap is applicable only to those beds that were being reimbursed on June 30, 1989. Any new beds coming on line on or after the cost reporting period used to set the June 30, 1989 Medicaid payment rate will not be subject to the $3.00 cap. In order for nursing facilities to recognize the increase in the Deemed Asset Value in future years, the $3.00 limit on the capital per diem payment will be inflated each year by the index for the rental value of a home computed as part of the CPI (i.e., the same index used to determine the Deemed Asset Value each year). This rate (rental value index) will be supplied by the Budget and Control Board's Division of Research and Statistical Services each year. The cap effective October 1, 1995, inflated by 4.2% is $3.99. Effective October 1, 1996, the cap will be frozen at $3.99.

State operated facilities will continue to be reimbursed their actual capital costs (depreciation, interest, lease, and amortization costs).

d) Lease and Sales

The South Carolina Department of Health and Human Services will treat any new lease or sale of a facility executed after December 15, 1981, as a related party transaction. Therefore, in the event of a sale after December 15, 1981, the provider's capital related cost will be limited to the lower of the sales price or the historical cost of the prior owner. In the event of a lease executed after December 15, 1981, the provider's capital related cost will be limited to the lower of the lease cost or the historical cost of the owner (lessor). The historical costs of the prior owner would include:

A. Depreciation expense of the prior owner.
B. Interest expense which will be limited to the prior owner's expense.
C. Prior owner's equity in the facility.

However, in the event of a sale or lease on and after July 1, 1989, the provider's (new owner) capital related cost will be limited to the cost of capital reimbursement received by the prior owner (i.e., cost of capital payment for the new owner will be the same as the old owner). No revaluation of assets will be recognized by the South Carolina Medicaid Program as a result of a sale.

No recapture of depreciation will be necessary from the prior owner unless the prior owner used accelerated depreciation in excess of the allowable straight line depreciation, or depreciation was overstated over the allowable straight line depreciation because of the application of a shorter useful life in calculating the depreciation.

II. Auditing

A) All cost reports will be desk reviewed by the Medicaid Agency. The Provider will be notified of the desk review exceptions and the provider has the right to respond within fifteen (15) days.

B) All cost reports are subject to on-site audit. Any overpayments determined as a result of on-site audits will be collected after issuing the final audit report and accounted for on the HCFA-64 report no later than the second quarter following the quarter in which the final audit report is issued. The provider has the right to appeal the final audit decision through the appeal process. The appeal decision will be binding upon the SCDHHS.

III. Medicaid Funding for Extraordinary Costs Relating to Hurricane Floyd

Effective October 1, 1999 through June 30, 2000, a pool of funds not to exceed $300,000 will be available to meet the extraordinary costs incurred by nursing facilities which were required to evacuate their residents due to the Mandatory Evacuation ordered by Governor Hodges as a result of Hurricane Floyd. The nursing facilities which can be considered eligible to participate in this funding must be located within the following coastal counties: Beaufort, Charleston, Colleton, Georgetown, Horry and Jasper.

The extraordinary costs incurred by nursing facilities would include the costs of transporting residents, the costs of housing the nursing facility residents in facilities other than long term care institutions, and the costs associated with housing the nursing facility staff which were taking care of the residents offsite.

In order for a nursing facility to request payment from this pool, the facility must submit copies of invoices and canceled checks relating to the extraordinary costs defined above. The nursing facility must also provide a copy of the census report(s) relative to the offsite stay, and identify the Medicaid recipients. Additionally, the nursing facility must report any insurance proceeds received from "business continuance" or "business interruption" insurance policies, or FEMA proceeds. These proceeds will be used to reduce any extraordinary costs claimed by the nursing facility.

Once the amount of unreimbursed extraordinary costs have been determined, the SCDHHS will determine Medicaid's share by applying the Medicaid utilization percentage determined from the census reports applicable to the offsite stay against the unreimbursed cost. Payment will be made to the provider via an adjustment. The costs associated with the extraordinary costs paid under this arrangement can not be included as allowable Medicaid costs in future cost reporting periods.

To be considered for this one time payment, all requests must be sent to the Bureau of Reimbursement Methodology and Policy at the following address:

South Carolina Department of Health and Human Services
Bureau of Reimbursement Methodology and Policy
Post Office Box 8206
Columbia, South Carolina 29202-8206

IV. Payment Determination

The rate cycle will be October 1 through September 30 and will be recomputed every twelve (12) months, utilizing the cost reports submitted in accordance with Section I, Cost Finding and Uniform Cost Reports, of the Plan.

Rates effective October 1, 1999 through September 30, 2000 will be recomputed annually based on the percentage of Level A Medicaid patients plus the Medicare co-insurance days for dual eligibles served by the facility. The DHHS Aries report reflecting nursing facility utilization by patient acuity based on January through June 1999 data will be used for the October 1, 1999 rates.

A. REIMBURSEMENT METHODOLOGY TO BE USED IN THE CALCULATION OF THE MEDICAID REIMBURSEMENT RATES

A prospective rate shall be established for each nursing facility separately based on the facility's cost report, and upon the standard costs which are developed in accordance with the methodology described below. In the event that audit adjustments are made to cost reports in accordance with Title XIX and Title XVIII Program rules, regulations, policies and procedures, the rate of payment will be established so as to be consistent with the facility's cost as audited. In the event that such adjustment is made subsequent to the date that a facility was paid an incorrect rate based on unaudited costs, the facility will be liable to repay to the South Carolina Department of Health and Human Services the difference between the audited rate and the interim rate for the contract period. In a case in which an audited rate exceeds the interim rate, the South Carolina Department of Health and Human Services will be liable to repay the facility the difference between the audited rate and the interim rate for the contract periods beginning on or after October 1, 1994.

Effective October 1, 1995, nursing facilities which do not incur an annual Medicaid utilization in excess of 1,000 patient days will receive a prospective payment rate which will represent the average industry rate at the beginning of each rate cycle. The average industry rate is determined by summing the October 1 rate of each nursing facility and dividing by the total number of nursing facilities. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

Effective December 1, 1998 a $.75 per patient day add on will also be included in each facility's reimbursement rate. This add on is provided to assist nursing facilities in retaining currently employed nurse aide staff, and comply with the new nurse aide staffing requirements effective January 1, 1999. Normally, this $.75 per patient day add on will not be cost settled, and will not be subject to change as a result of a field audit. However, if a nursing facility is cited during a South Carolina Department of Health and Environmental Control certification survey for inadequate nurse aide staff during the time period in which the $.75 nurse aide add on is provided, it will be required to submit financial and statistical information relating to the expenditure of the $.75 nurse aide add on. If as a result of our review a payback is warranted, it will not exceed the total amount reimbursed through the $.75 nurse aide add on.

Effective October 1, 1999, a CNA Vacancy Add on will be included in each qualifying facility's reimbursement rate. This add on will be provided in order that nursing facilities can address the industry wide nurse aide staffing turnover problem which was enhanced by a change in the minimum staffing requirements effective January 1, 1999.

The add on is computed using data supplied by each nursing facility as requested by the SCDHHS. The average number of CNA vacancies for each individual facility is computed using the four (4) consecutive weeks with the highest CNA vacancy factor through July 31, 1999 of each facility's FYE 1999 cost reporting period. Once the average number of CNA vacancies are calculated for each facility, the SCDHHS will convert the vacancies to hours based upon 8,750 hours per vacancy. The facility specific nurse aide new hire hourly wage rate as reported by the provider is multiplied by the average number of CNA vacancy hours to determine the total amount of CNA vacancy salary costs. The salary costs are then multiplied by each facility's nurse aide fringe benefit percentage as determined based upon the information reported on the FYE September 30, 1998 cost report, or the cost report which was used to establish the facility's rate effective October 1, 1999. The total CNA vacancy salary costs and applicable fringe benefits cost are added together and then divided by the total patient days as reported on the facility's FYE September 30, 1998 cost report (or the cost report used to set the facility's rate effective October 1, 1999), with minimum occupancy at 97%, to determine a per patient day cost. The per patient day cost is then multiplied by each facility's SFY 1999 Medicaid permit days in order to determine the total projected Medicaid cost for each facility. Because the total projected Medicaid cost applicable to the CNA vacancies exceeded the $4.5 million provided by the South Carolina General Assembly, each qualifying facility received 22.18% of the per patient day cost as the CNA vacancy add on.

In order to satisfy the CNA vacancy add on spending requirement for facilities which filed annual 1998 cost reports, the SCDHHS will use the following methodology:

(A) The SCDHHS will use the FYE September 30, 1998 or June 30, 1998 cost reporting period to set the CNA base year cost.

(B) The CNA base year cost will include CNA/orderly salary costs and associated fringe benefits, plus CNA/orderly pool costs.

(C) If the sum of the facility's allowable costs of General Services, Dietary, and Laundry, Housekeeping, & Maintenance exceeds the sum of the three cost center standards, SCDHHS will compute the percentage of reimbursed allowable CNA/orderly cost by dividing the sum of the three cost center standards by the sum of the allowable costs of the three cost centers. This percentage will then be applied to 100% of the CNA costs as defined in (B) above to determine the CNA base year costs.

(D) A desk audited CNA per diem cost will be calculated from the FYE 1998 cost reporting period using actual occupancy or 97% occupancy, whichever is higher.

(E) To inflate the FYE 1998 costs forward to the October 1, 1999 through September 30, 2000 rate period, the desk audited CNA per diem cost from the FYE 1998 cost report will be inflated by 3%.

(F) The nursing facility specific CNA vacancy add on will be added to the trended FYE 1998 desk audited CNA per diem cost as determined in (E) above to set the spending requirement, on a per diem basis, for CNA/orderly salaries, fringe benefits, and pool costs during the FYE September 30, 2000 or June 30, 2000 cost reporting period.

(G) Using the September 30, 2000 or June 30, 2000 cost reporting period, the desk audited CNA per diem cost, consisting of CNA/orderly salary costs, associated fringe benefits, and pool costs will be calculated using actual occupancy or 97% occupancy, whichever is higher.

(H) SCDHHS will then compare the FYE 2000 CNA per diem as determined in (G) to the CNA per diem as determined in (F). If the CNA per diem as determined in (G) exceeds the CNA per diem as determined in (F), the provider has satisfied the spending requirement and thus no funds are due the SCDHHS. However, if the CNA per diem, as determined in (G), is less than the CNA per diem as determined in (F), the SCDHHS will recoup the difference (but not to exceed the facility specific CNA vacancy add on amount) paid to the facility during the period October 1, 1999 through September 30, 2001.

In order to satisfy the CNA vacancy add on spending requirement for facilities which filed less than a full year (i.e., Actual) cost report, the SCDHHS will use the following methodology:

(A) The SCDHHS will use the short/actual cost report ending on or after FYE September 30, 1998 but prior to FYE September 30, 1999 to set the CNA base year cost.

(B) The CNA base year cost will include CNA/orderly salary costs and associated fringe benefits, plus CNA/orderly pool costs.

(C) If the sum of the facility's allowable costs of General Services, Dietary, and Laundry, Housekeeping, & Maintenance exceeds the sum of the three cost center standards, SCDHHS will compute the percentage of reimbursed allowable CNA/orderly cost by dividing the sum of the three cost center standards by the sum of the allowable costs of the three cost centers. This percentage will then be applied to 100% of the CNA costs as defined in (B) above to determine the CNA base year costs.

(D) A desk audited CNA per diem cost will be calculated from the base year cost report period as determined in (A) above using actual occupancy or 97% occupancy, whichever is higher.

(E) To inflate the base year costs forward to the October 1, 1999 through September 30, 2000 rate period, the desk audited CNA per diem cost from the base year cost report period will be inflated by 3%.

(F) The nursing facility specific CNA vacancy add on will be added to the trended base year desk audited CNA per diem cost as determined in (E) above to set the spending requirement, on a per diem basis, for CNA/orderly salaries, fringe benefits, and pool costs during the FYE September 30, 2000 or June 30, 2000 cost reporting period.

(G) Using the September 30, 2000 or June 30, 2000 cost reporting period, the desk audited CNA per diem cost, consisting of CNA/orderly salary costs, associated fringe benefits, and pool costs will be calculated using actual occupancy or 97% occupancy, whichever is higher.

(H) SCDHHS will then compare the FYE 2000 CNA per diem as determined in (G) to the CNA per diem as determined in (F). If the CNA per diem as determined in (G) exceeds the CNA per diem as determined in (F), the provider has satisfied the spending requirement and thus no funds are due the SCDHHS. However, if the CNA per diem, as determined in (G), is less than the CNA per diem as determined in (F), the SCDHHS will recoup the difference (but not to exceed the facility specific CNA vacancy add on amount) paid to the facility during the period October 1, 1999 through September 30, 2001.

COMPUTATION OF REIMBURSEMENT RATE

)VIDER NAME:
.(OVIDER NUMBER:
REPORTING PERIOD: FYE 9/30/98

REFERENCE #
DATE EFF. 10-1-99

NURSING FACILITY
CODE
1

TOTAL PATIENT DAYS:
TOTAL PROVIDER BEDS:

% OCCUPANCY 0.00%

% LEVEL A 0.000

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
ITILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR 3.00%				0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES				0.00
CNA (75 cents) ADD-ON				0.75
NURSE AIDE STAFFING ADD-ON				0.00
REIMBURSEMENT RATE				0.00

SC: MA 99-012
EFFECTIVE DATE: 10/01/99
RO APPROVED: 3/10/00
SUPERSEDES: MA 98-010

Effective October 1, 1995, for the purpose of establishing all cost center standards, the facilities are grouped according to bed size. The bed groupings are:

0 Through 60 Beds
61 Through 99 Beds
100 Plus Beds

B. ALL STANDARDS, EXCEPT FOR GENERAL SERVICES, FOR PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED) WILL BE COMPUTED USING PROPRIETARY FACILITIES ONLY. EFFECTIVE OCTOBER 1, 1997, HOSPITAL BASED PROPRIETARY NURSING FACILITIES WILL BE EXCLUDED FROM THE COMPUTATION OF ALL STANDARDS, EXCEPT FOR GENERAL SERVICES. THE GENERAL SERVICE STANDARD WILL BE COMPUTED USING PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED). A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

   a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.

   b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 97%).

   c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

   d. Calculate the standard by multiplying the mean by 105%.

   e. The establishment of the General Services standard for all nursing facilities (excluding state owned facilities) will be based on the average of the percentage of Medicaid Level A patients/total Medicaid patients served. Rates effective October 1, 1999 through September 30, 2000 will be recomputed annually based on the percentage of Level A Medicaid patients plus the Medicare co-insurance days for dual eligibles served by the facility. The DHHS Aries report reflecting nursing facility utilization by patient acuity based on January 1999 through June 1999 data will be used for the October 1999 rates. The General Services standard for each separate facility will be determined in relation to the percent of Level A Medicaid patients served, i.e., the base standard determination in (d.) above will be decreased as the percent of Level A Medicaid patients is decreased and increased as the percent of Level A Medicaid patients is increased.

2. Dietary; Laundry, Maintenance and Housekeeping; Administration and Medical Records & Services: The standard for each of these three cost categories is calculated as follows:

a. Accumulate all allowable cost for each cost center for all facilities in each bed size.

b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 97%).

c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

d. Calculate the standard by multiplying the mean by 105%.

C. RATE COMPUTATION:

Rates will be computed using the attached rate computation sheet (see page 18) as follows:

1. For each facility, determine allowable cost for the following categories:
COST SUBJECT TO STANDARDS:

General Services
Dietary
Laundry, Maintenance and Housekeeping
Administration and Medical Records & Services

COST NOT SUBJECT TO STANDARDS:

Utilities
Special Services
Medical Supplies
Property Taxes and Insurance Coverage - Building and Equipment
Legal Fees

2. Calculate actual allowable cost per day based on the cost reports for each category by dividing allowable cost by actual days. If the facility has less than 97% occupancy, actual days will be adjusted to reflect 97% occupancy.

3. For cost subject to standards, the lower of cost determined in step 2 or the cost standard will be allowed in determining the facility's rates. Effective October 1, 1997, the General Services, Dietary, and Laundry, Housekeeping, and Maintenance cost centers are combined. Therefore, compare the sum of the allowable cost of these three cost centers to the sum of these three cost standards.